Request and Authorization for Disclosure of Health Information

PLEASE PRINT or TYPE

EFFECTIVE AS OF _____

This is an authorization requesting United Concordia Companies, Inc. or its subsidiary as shown on the list below (UCCI) to release individual health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or by state law protecting the privacy of health information. I hereby authorize the use and disclosure of the individually identifiable health information as described below.

(1) The request for release of information is being made **for** the dental plan member identified below.

_____ _____
Identification Number Date of Birth

_____ _____
Member's Name Telephone Number

_____
Mailing Address

(2) Specific description of information that may be used/disclosed:

Claims Information Payment Information

Other Information (must provide specific description): _____

_____

_____

(3) The information will be used/disclosed for the following purpose(s):

Obtaining Claims Information or Payment Information for the Resolution of Claim Processing or Payment Issues

Other:_____

_____

_____

(4) Persons/organizations **authorized to receive** the information:

Family Members (must list names and relationship):_____

_____

All Group Health Plan Representatives at member's place of employment (provide name of member's employer):_____

_____

Other (must list names and relationship to member):
_____

_____

(5) I understand that I may revoke this authorization at any time by sending a written notice of my revocation to the address listed below. I understand that revocation of this authorization will not affect any action UCCI or it's subsidiaries, affiliates, business associates, etc. took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, UCCI may not use or disclose my health information for any reason except those described in UCCI's Notice of Privacy Policies and Practices. Unless otherwise revoked, this authorization will expire on the following date, event, or circumstance.

This authorization expires on [upon] _____[Insert applicable date, event or circumstance]

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I release UCCI, its affiliated companies, employees, officers and business associates from legal liability for any recipient's use or disclosure of information released by UCCI in reliance on this authorization.

_____ _____

Signed (member or personal representative) Date

_____

Printed name of signature above (member's personal representative)

_____

Description of the representative's authority to act for the member

You are entitled to a copy of this authorization after you sign it.

Any revocation or change to this authorization, or any questions regarding its legal effect, should be addressed to:

United Concordia Companies, Inc.
Dental Customer Service
P.O. Box 69420
Harrisburg, PA
17106-9420

If you have any questions, please call Dental Customer Service at the telephone number located on the back of your identification card.

UNITED CONCORDIA COMPANIES, INC., AND SUBSIDIARIES

Just Dental of Delmarva, Inc.
United Concordia Dental Plans, Inc.
United Concordia Dental Corporation of Alabama
United Concordia Dental Plans of Arizona, Inc.
United Concordia Dental Plans of California, Inc.
United Concordia Dental Plans of Colorado, Inc.
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